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ABSTRACT

The First National Indian Conference on Aging, sponsored in 1976 by the National Tribal Chairmen's Association, recommended action to correct some of the serious problems detracting from the physical, psychological, and spiritual well-being of the Indian elderly. A principal concern of the Conference was the urgent need for on-reservation nursing homes or sheltered care facilities to provide institutional care to older Indians in a culturally familiar, personal environment. The funding for such facilities, however, appeared to make the prospect of independent, tribal nursing homes unfeasible. The Conference found some states refused to license reservation homes because the states lacked regulatory jurisdiction; eligibilty for construction and modernization of hospitals and other medical facilities under the Hill-Burton Act are available only to the states; and advisory groups established for the purpose of determing use of those funds have little sympathy for Indian projects. In a general approach, the paper deals with potential state jurisdictional barriers to the establishment and operation of tribal nursing homes. (ERB)

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# INDIAN TRIBAL NURSING HOMES AND STATE REGULATIONS

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# INDIAN TRIBAL NURSING HOMES AND STATE REGULATIONS */

## INTRODUCTION

In 1976, the First National Indian Conference on Aging, sponsored by the National Tribal Chairmen's Association, recommended action to correct some of the serious problems detracting from the physical, psychological, and spiritual well-being of the Indian elderly.1/ A principal concern of the Conference was the urgent need for on-reservation nursing homes or sheltered care facilities to provide institutional care to older Indians in a culturally familiar, personal environment.2/ The funding for such facilities, however, appeared to make the prospect of independent, tribal nursing homes infeasible. The Conference found that some states refused to license reservation homes because the states lacked regulatory jurisdiction. At the same time, eligibility for the construction and modernization of hospitals

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*/ The primary authors of this paper were John R. Keys, Jr. and Jane Petkofsky.

1/ The Indian Elder, A Forgotten American: Final Report on the First National Indian Conference on Aging, Phoenix, Arizona, June 15-17, 1976 (1978) (prepared by Juana P. Lyon; sponsored by National Tribal Chairmen's Association).

2/ Id. at 9-11.

and other medical facilities under the Hill-Burton Act[3/] are available only to the states, and advisory groups established for the purpose of determining the use of those funds, generally, have little sympathy for Indian projects. The Conference recommended that Indian nursing homes or sheltered care facilities should not be subject to state regulation or control, but should instead be governed by federal regulations, similar to those applicable to Indian Health Service hospitals.

This paper deals with potential state jurisdictional barriers to the establishment and operation of tribal nursing homes. This paper is necessarily general in its approach. We are assuming health care facilities located on the reservation and serving Indian people. Moreover, it is beyond the scope of the paper to address special circumstances that may exist as a result of treaties or specialized legislation. Also, a final caveat: The law in this area is not settled. Answers to specific jurisdictional questions may ultimately depend on federal policy decisions or the different approaches of federal courts.

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3/ Pertinent portion codified at 42 U.S.C. §291 (1970).

SUMMARY OF CONCLUSIONS

Examination of federal statutory and case law dealing with state jurisdiction over reservations and tribal life leads to the conclusion that states generally have no power to regulate directly nursing homes established on Indian reservations where such homes provide services primarily to Indian patients.

Congress has not granted broad regulatory authority over Indian reservation lands and activities to the states. Moreover, the present Indian health care system is overwhelmingly governed by federal regulation. There are, however, several situations in which state standards must be met as a prerequisite to participation in a federal program. This must be distinguished from an outright grant of jurisdiction to the states, in which case the state would be authorized to enforce its regulatory requirements on the reservation. Rather, the federal approach is to incorporate certain state requirements into federal law with enforcement responsibility remaining with the federal government.

Under the Indian Self-Determination Act,[4/] state standards are not imposed where the administration of health programs, either through a contract with the Indian

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4/ The major provisions of the Indian Self-Determination and Educational Assistance Act, Pub. L. No. 93-638 (1975), are codified at 25 U.S.C.A. §450 (Supp. 1978).

Health Service (IHS) or with the aid of a grant, is by a tribe; however, state-developed standards apply where a tribe obtains a grant for the construction of a health care facility. The regulations require compliance with a series of state and local zoning and building requirements.

An Indian tribe may further be required to operate a health facility in accordance with state standards governing like facilities, if the tribe desires to take advantage of the maximum available federal assistance. The Indian Health Care Improvement Act[5/] makes Medicaid and Medicare funds available to tribally-operated IHS facilities, conditioned upon compliance with all standards established for other Medicaid and Medicare recipients. These standards include those established by the state. While such facilities must normally be licensed by the state, state licensure is not required of IHS facilities.

In summary, the authority for regulation of on-reservation nursing homes originates in federal, not state, law. If, however, all potential resources are to be utilized by the tribes in developing health care facilities for their elder members, regulatory standards established by the states may have to be met.

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5/ Pub. L. No. 94-437 (1976), 25 U.S.C.A. §§1601-75 (Supp. 1978).

CONSTITUTIONAL AUTHORITY FOR FEDERAL PREEMPTION

The federal government's power over Indian tribes and the authority to legislate with respect to Indian matters derives from the Constitution[6/] and is plenary.[7/] Accordingly, the states have no power over Indian affairs unless conferred by federal statute or by special circumstance.[8/] In Worcester v. Georgia, decided in 1832, the Supreme Court declared:

> The Cherokee nation, then, is a distinct community, occupying its own territory, with boundaries accurately described, in which the laws of Georgia can have no force, and which the citizens of Georgia have no right to enter, but with the assent of the Cherokees themselves, or in conformity with treaties, and with acts of Congress. 9/

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6/ The commerce clause provides: "The Congress shall have Power...To regulate Commerce...with the Indian Tribes." U.S. Const. art. I, §8, cl.3. "[The President] shall have Power, by and with the Advice and Consent of the Senate, to make treaties, provided two-thirds of the Senators present concur." U.S. Const. art. II, §2, cl.2.

7/ See, e.g., McClanahan v. State Tax Comm'n of Ariz., 411 U.S. 164, 172 n.7 (1973); American Indian Policy Review Commission, Final Report, Law Consolidation, Revision and Codification, 94th Cong. 2d Sess., 106 (Comm. Print 1976) [hereinafter cited as AIPRC, Final Report].

8/ F. Cohen, Handbook of Federal Indian Law 117 (U.N. Mex. 1971).

9/ 31 U.S. 515, 560 (1832).

While some of the broader principles of Worcester have been eroded, the notion that a state cannot unilaterally impose its laws within the boundaries of an Indian reservation, with respect to matters involving or affecting only Indians, has been, for the most part, consistently upheld by the Supreme Court.[10/]

This recognition that states have no power to regulate tribal matters on the reservation has traditionally been based on the doctrine of tribal sovereignty.[11/] This doctrine, in its most recent restatement, holds that Indian tribes possess those powers of self-government that they have not expressly relinquished, that Congress has not taken from them, or that are not inconsistent with their status as subjects of the overriding sovereignty of the United States.[12/] The tribal sovereignty doctrine, however, is of primary concern in determining the validity of tribal actions. Where the issue is one of state assertion of its jurisdiction on the reservation, tribal sovereignty has been regarded as a "backdrop" against which applicable treaties and statutes must be read.[13/]

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10/ Sullivan, State Civil Power over Reservation Indians, 33 Mont. L. Rev. 291, 296 (1972).

11/ This was the basis of the Worcester decision. 31 U.S. 515.

12/ AIPRC, Final Report, supra note 7, at 99; Oliphant v. Suquamish Indian Tribe, 98 S.Ct. 1011 (1978); United States v. Wheeler, 98 S.Ct. 1079 (1978); Santa Clara Pueblo v. Martinez, 98 S.Ct. 1670 (1978).

13/ 411 U.S. 164, 172 n.2.

The inquiry in cases of state assertion of jurisdiction is whether the relevant treaties and statutes describe a sphere of activity which is left exclusively to the federal government and/or the Indians themselves.[14] In such areas, where the state has no legitimate interest, state action is barred on the basis of a total federal/tribal preemption of the field. This was the Supreme Court's approach in McClanahan v. State Tax Commission of Arizona.[15] The concept of preemption, however, has been invoked in more diverse circumstances in which the states have been recognized as possessing otherwise legitimate claims to jurisdiction. For example, federal courts have invalidated state imposition of a tax on reservation cigarette sales to non-Indians on a preemption theory where the tribe had enacted its own taxing ordinance[16] and have barred imposition of a county

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14/ Id. at 179-80.

15/ Id. at 164; see also Warren Trading Post Co. v. Ariz. State Tax Comm'n, 380 U.S. 685 (1965).

16/ Confederated Tribes of the Colville Indian Reservation v. State of Washington, 466 F.Supp. 1339 (E.D. Wash. 1978); see also Fisher v. District Court, 424 U.S. 382 (1976).

zoning ordinance where it interfered with Bureau of Indian Affairs (BIA) and IHS programs.[17]

Analysis of the question of state regulation of on-reservation nursing homes or sheltered care facilities begins with consideration of whether federal and/or tribal action have delineated an exclusive province from which the states are excluded and have, therefore, preempted state exercise of authority.

FEDERAL PREEMPTION BY STATUTE

The Snyder Act of 1921 provides the basic authority for Indian health programs, empowering the BIA to expend such monies as Congress might appropriate "for the benefit, care, and assistance of Indians throughout the United States...[including the] relief of distress and conservation of health."[18] The Secretary of the Interior was later authorized to enter into contracts with the states and territories or with private corporations to provide medical attention to Indians within the respective states and territories.[19]

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17/ Santa Rosa Band of Indians v. Kings County, 532 F.2d 655 (9th Cir. 1975). Closely related to the preemption concept where non-Indian interests are involved is the holding of Williams v. Lee, 358 U.S. 217, 220 (1959), in which the validity of state action has been determined by whether it infringes the right of reservation Indians to make their own laws and to be ruled by them.

18/ 25 U.S.C. §13 (1970).

19/ 25 U.S.C. §452 (1970).

In 1954, Congress transferred to the Public Health Service, under the direction of the Secretary of Health, Education, and Welfare (HEW), primary responsibility for providing health care services to Indian people.[20] Within HEW, the Division of Indian Health, later renamed the Indian Health Service, was the coordinating agency. This transfer of function was effected in an effort, in part, to avoid duplication among federal agencies of responsibility for health-related services. HEW was seen as the likely agency to assume the lead role, since that agency was already involved in directing many grants-in-aid programs which provided partial, federal funding for state-administered health delivery programs.[21] The Transfer Act also authorizes the Secretary to enter into contracts with state agencies or private non-profit organizations transferring to them Indian hospitals or health facilities to be operated primarily to meet the

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20/ Act of August 5, 1954 (Transfer Act), 42 U.S.C. §2001 et seq. (1970).

21/ S. Rep. No. 1530, 83d Cong., 2d Sess. (1954), reprinted in [1954] U.S. Code Cong. & Ad. News 2918, 2019; H. Rep. No. 870, 83d Cong., 1st Sess. (1953), reprinted in [1954] U.S. Code Cong. & Ad. News 2918, 2926.

health needs of Indians.[22] The transfer of facilities constructed for a specific tribe or group of tribes could be effected only with tribal consent.[23] Apparently, no action has ever been taken pursuant to this authority.[24] IHS was later given authority over the construction and maintenance of sanitation facilities, as well.[25]

Congress enacted the Indian Health Facilities Act[26] in 1957, amending the Transfer Act, to provide assistance to public and non-profit agencies or organizations for the construction of hospitals to meet the needs of Indians, where doing so would be more effective than construction of health facilities by the federal government directly. As a condition for assistance under the Act, the Secretary of HEW is required to obtain assurance from the recipient that the hospital will be operated and maintained in compliance with the state standards for hospitals which

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22/ 42 U.S.C. §2002.

23/ Id.

24/ American Indian Policy Review Comm'n, Report on Indian Health, 94th Cong., 2d Sess., 34 (Comm. Print 1976).

25/ 42 U.S.C. §2004.

26/ 42 U.S.C. §2005 et seq. (1970).

receive federal aid under the general, HEW program for construction and modernization of hospitals and medical facilities.[27]

Undoubtedly, Congress did not contemplate tribal construction of hospitals when it passed the Indian Health Facilities Act, though a tribe conceivably could be eligible for funds under that Act. However, the possibility of significant tribal participation in IHS programs was addressed directly in the Indian Self-Determination Act of 1975[28] the first important piece of legislation affecting Indian health since the Transfer Act.

In general, the Self-Determination Act authorizes tribes to assume responsibility, through various mechanisms,

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27/ 42 U.S.C. §2005b.

The general grant program for the construction of hospitals is found at 42 U.S.C. §§291-291j (1970). It should be noted that for purposes of the Indian Health Facilities Act the term "hospital" includes "diagnostic or treatment centers and general hospitals, and related facilities, such as laboratories, outpatient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care." 42 U.S.C. §2005e(a) (emphasis added) Inclusion of nursing homes for the elderly in this definition would appear to depend upon the character of the services provided.

28/ 25 U.S.C.A. §450 et seq.

for all or part of the programs administered by IHS.[29] It contemplates tribal participation in health care programs through two vehicles: contracts with HEW and monetary grants to construct facilities or support health programs.[30] Section 103 of the Act[31] directs the Secretary of HEW to enter into contracts with any Indian tribe, upon request of the tribe, to carry out any of the health programs established pursuant to the authority granted to the Secretary under the Transfer Act and amendments thereto.[32] The Secretary of HEW is further authorized to make grants to tribes or tribal organizations, from funds appropriated to IHS, for the "development, construction, operation, provision, or maintenance of adequate health facilities or services."[33] Grants are also available for such activities as planning

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29/ 25 U.S.C.A. §450g.

30/ 25 U.S.C.A. §450h.

31/ 25 U.S.C.A. §450g.

32/ The Act contains a parallel section whereby the tribes may contract to administer programs currently administered by BIA. 25 U.S.C.A. §450f.

33/ 25 U.S.C.A. §450h(b)(1).

and training designed to improve the capacity of a tribe or tribal organization to enter into contracts to provide health services.[34] HEW regulations outline the requirements with which tribal programs must comply to qualify for either grants or contracts.[35]

The Indian Health Care Improvement Act[36] is the most recent legislative initiative toward upgrading the quantity and quality of health services available to Indians. In that Act, Congress expressly found that health services for Indians are required by the federal government's "historical and unique legal relationship with" the American Indian people.[37] In fulfillment of the special responsibilities and legal obligation of this relationship, Congress declared it a national policy to provide the highest possible health status to Indians and to provide the resources necessary to effect that policy.[38]

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34/ 25 U.S.C.A. §450h(b)(2).

35/ 42 C.F.R. §§36.1-36.237 (1976). Subpart H deals with grants for the development, construction and operation of facilities and services. Subpart I applies to contracts under the Self-Determination Act.

36/ 25 U.S.C.A. §§1601-75.

37/ 25 U.S.C.A. §1601(a).

38/ 25 U.S.C.A. §1602.

In furtherance of its policy declaration, Congress launched a major seven-year thrust to bring Indian health status to levels comparable with the rest of the population by authorizing expenditures of $84.3 million in the first three years alone for patient care, field health, dental care, mental health, therapeutic and residential treatment centers, training of traditional Indian mental health practitioners, alcoholism treatment, and maintenance and repair of facilities.[39] The Act further authorized expenditures of over $234 million for the construction and renovation of Indian hospitals, health centers, health stations, and other IHS facilities.[40]

Providing for the health care of on-reservation Indian populations is fundamentally a federal responsibility.[41] While the federal delivery system remains plagued by budgetary and staff insufficiency, the fact remains that Indians -- especially those living on or near reservations -- receive the bulk of their health care services from IHS.[42] IHS operates 86 service units across the country which include 51 hospitals, 83 health centers, and 300 field stations.[43]

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39/ 25 U.S.C.A. §1621(c), §1621(e).

40/ 25 U.S.C.A. §1631.

41/ See AIPRC, Final Report, supra note 7, at 376.

42/ Id. at 378, 385.

43/ Id.

Much of the health care services for Indians is actually provided by private facilities pursuant to contracts with IHS.44/

IHS, of course, regulates the operations of its own facilities. Federal regulation further provides that, in order to be eligible for operational or maintenance grants under the Self-Determination Act, tribal projects must provide services at a level not less than that provided by IHS or which IHS has identified as appropriate.45/ Construction and equipment standards for Self-Determination grants are also prescribed by federal regulation; the federal rules incorporate national uniform codes or, in some cases, state and local codes.46/

The longstanding and pervasive responsibility of the federal government for matters concerning the conservation of Indian health argues strongly for federal preemption of the field, especially on the reservation. To the extent individual tribes might choose to construct and operate on-reservation facilities pursuant to federal grant or contract, and in accord with federal regulations,

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44/ Id. at 379-80.

45/ 42 C.F.R. §36.105(i) (1977).

46/ 42 C.F.R. §36.110(b)(11), 36.101-36.121, app. A (1977).

such tribes could validly claim preemption and exclusion from the reach of direct state regulatory authority. Thus, even without direct, federal involvement, a tribal nursing facility could be found beyond state regulation, where the tribe has taken steps pursuant to its own inherent or delegated authority to regulate its own facility.

Admittedly, the concept of tribal nursing homes or extended care facilities is somewhat novel and, to the best of our knowledge, there has not been extensive federal or tribal involvement in this area. Consequently, many of the definitional sections of applicable laws and regulations do not specifically mention such facilities. For example, the Indian Health Facilities Act expressly excludes from its definition of "hospital" those facilities "furnishing primarily domiciliary care."[47/] Such factors detract from the preemption concept. However, the authority of the Snyder Act, the Self-Determination Act and the Indian Health Care Improvement Act is quite broad,[48/] and it may safely be asserted that federal or tribal construction and operation of nursing homes on reservations generally would preempt state regulation.

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47/ 42 U.S.C. §2005e(a).

48/ See discussion supra at pp. .

THE EFFECT OF PUBLIC LAW 83-280

The preemption argument is general in nature and subject to modification by specific acts of Congress. The principal legislation subjecting reservation Indians to state jurisdiction is the Act of August 15, 1953, as amended, or Public Law 83-280 (P.L. 280).[49/]

P.L. 280 conferred upon five states[50/] jurisdiction over civil causes arising in Indian country between Indians or to which Indians are parties, and offenses committed by or against Indians in Indian country. It gave state civil and criminal laws the same force and effect in Indian country as elsewhere within the state. The Act also allowed all other states to take the steps necessary for the assumption of civil and criminal juris-

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49/ 18 U.S.C. §1162 (1970) (criminal jurisdiction); 28 U.S.C. §1360 (1970) (civil jurisdiction).

50/ California, Nebraska and Wisconsin were given jurisdiction over all Indian country within the State; Minnesota, over all Indian country except the Red Lake Reservation; and Oregon over all Indian country except the Warm Springs Reservation. 18 U.S.C. §1162(a); 28 U.S.C. §1360(a). A sixth state, Alaska, was added in 1958, under P.L. 85-615.

diction.[51] A number of states assumed full or partial jurisdiction over Indian country under this provision, before it was repealed in 1968 as a part of the Indian Civil Rights Act (ICRA), which required tribal consent to a state's assumption of jurisdiction.[52]

The assumption of P.L. 280 jurisdiction by a state does not result in jurisdiction over all matters and the case law testing the reach of such jurisdiction is growing. Thus, even where a tribal nursing home is established on a reservation within a "P.L. 280" state, the state may not necessarily be entitled to impose its full regulatory scheme.

Limitations on the scope of P.L. 280 have been identified on several different bases. The Ninth Circuit resolved some of the issues regarding the reach

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51/ Various state enabling acts and state constitutions contained clauses which specifically disclaimed jurisdiction over the Indian tribes. E.g., Arizona Enabling Act, 36 Stat. 569; Ariz. Const., art 20, ¶4, A.R.S.; New Mexico Enabling Act, 36 Stat. 558-59; Utah Enabling Act, 28 Stat. 108. While earlier cases dealt at length with the breadth of such disclaimers, such interpretation is largely academic since the Supreme Court decisions in Williams v. Lee, 358 U.S. 217 (1959), and Kennerly v. District Court, 400 U.S. 423 (1971). See also Sullivan, supra note 10, at 294.

52/ 25 U.S.C. §1321, 1322 (1970).

of P.L. 280 in Santa Rosa Band of Indians v. Kings County,[53] which dealt with the applicability of a county zoning ordinance and building code to the Santa Rosa Rancheria in California. The court started from the proposition that "any concurrent jurisdiction that the states might have possessed to regulate the use of reservation lands by Indians has long ago been preempted by extensive Federal policy and legislation."[54] P.L. 280 preempts and reserves to the federal government or the tribe any jurisdiction not actually granted to the states.[55] The court found that P.L. 280 did not confer jurisdiction upon Santa Rosa County to enforce its zoning or building codes on the reservation because, first, P.L. 280 was not a grant of jurisdiction to local governments, second, the regulations at issue constituted "encumbrances" on Indian lands, and were, therefore, impermissible under P.L. 280's "savings clause," and, finally, the application of the ordinances would be inconsistent with federal programs administered by BIA and IHS.

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53/ 532 F.2d 655.

54/ Id. at 658; McClanahan, 411 U.S. at 176, 176 n.15; Mescalero Apache Tribe v. Jones, 411 U.S. 145 (1973); Warren Trading Post, 380 U.S. 658; Williams v. Lee, 358 U.S. at 220-21.

55/ 532 F.2d at 658-59.

Applying the principle that ambiguities in federal statutes dealing with Indians should be construed in the manner most favorable to the Indians, the court had "little difficulty" concluding that the application of local law would have a devastating impact on tribal self-government and development of reservation resources.[56] Therefore, the court concluded that P.L. 280 must be construed to subject the reservation only to state laws, not local ordinances.[57] What Congress contemplated, the court concluded, was that a tribal government would function more or less as a county or local government, and therefore, like a county government, would have the authority to regulate matters of local concern within its borders.[58]

A further impediment to the application of the zoning and building ordinances at issue in Santa Rosa

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56/ Id. at 660; Worcester, 31 U.S. at 393; McClanahan, 411 U.S. at 174-5.

57/ 532 F.2d at 661.

58/ Id. at 663; the court in Santa Rosa noted that their decision does not bar "all incidental on-reservation consequences" of local regulations, and would probably not prohibit a county from charging reservation Indians the same fee for county-supplied water as is charged in other county residents. The controlling principles enunciated in the decision must be applied on a case-by-case basis. Id. at 669.

is the so-called "savings clause" of P.L. 280.[59] There are two aspects of this exception to state jurisdiction: a state may not impose upon a tribe any law which constitutes an encumbrance of trust property, nor may it regulate the use of trust property in a manner inconsistent with federal statute.

The court in Santa Rosa interpreted the encumbrance exception of P.L. 280 very broadly and denied the state the power to apply zoning regulations to the reservation.[60] This interpretation is supported by a federal regulation, which provides that none of the laws or regulations of any state or political subdivision thereof limiting,

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59/ 28 U.S.C. §1360(b) (1970) provides:

> Nothing in this section shall authorize the alienation, encumbrance, or taxation of any real or personal property, including water rights, belonging to any Indian or Indian tribe, band or community that is held in trust by the United States...; or shall authorize regulation of the use of such property in a manner inconsistent with any Federal treaty, agreement, or statute or with any regulation made pursuant thereto; or shall confer jurisdiction upon the State to adjudicate, in probate proceedings or otherwise, the ownership or rights to possession of such property or interest therein.

60/ 532 F.2d at 667.

zoning or otherwise regulating the use of land shall apply to trust lands.61/

The full spectrum of state law and regulation governing health facilities undoubtedly can not be dismissed as "encumbrances." However, where a regulation is in the nature of a zoning ordinance or building code, which establishes minimum standards for the construction of hospitals or nursing homes, there is a strong argument that the regulation consitutes an "encumbrance" and is not applicable to the reservation under P.L. 280.

In regards to the second aspect of the savings clause the court in Santa Rosa found that the local ordinances at issue were inconsistent with federal statutes authorizing BIA and IHS programs.62/ The efficient administration of these federal programs requires uniform, federal standards and the imposition of local ordinances would add expense and detract from the program goals. Insofar as local regulation interferes with the implementation of programs authorized under these statutes, such

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61/ 25 C.F.R. §1.4 (1977). There has been some controversy over the validity of this regulation, but the court concluded that §1.4 neither exceeds statutory authority, nor is it in derogation of the jurisdictional grant of P.L. 280. 532 F.2d at 665-67. See also Goldberg, Public Law 280: The Limits of State Jurisdiction over Reservation Indians, 22 U.C.L.A. L. Rev. 535, 586 n.229 (1975).

62/ The Housing Improvement Program was administered under the authority of 25 U.S.C. §131 (1970), and the IHS sanitation services are provided pursuant to 42 U.S.C. §2004a (1970).

regulations are "inconsistent" with federal statutes.[63] This rationale is a variation of the more general concept, discussed above, that a state has no regulatory authority in an area which has been preempted by extensive, federal regulation.[64]

Shortly after the Ninth Circuit decided the Santa Rosa case, the United States Supreme Court in Bryan v. Itasca County struck down a Minnesota county's imposition of a personal property tax on individually owned Indian, on-reservation property and construed P.L. 280's grant of civil jurisdiction very narrowly.[65] Not only was the taxing authority asserted in Bryan not conferred upon the state, but the Act, itself, and its legislative history, the Court stated, "virtually compels our conclusion that the primary intent of §4 was to grant jurisdiction over private civil litigation involving reservation

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63/ 532 F.2d at 668.

64/ See note 50 supra and accompanying text. Neither McClanahan nor Warren Trading Post dealt with states which have assumed jurisdiction under P.L. 280. 411 U.S. 164; 380 U.S. 685.

65/ 426 U.S. 373 (1976) (the tax involved was a personal property tax on a mobile home located on the Leech Lake Reservation, Minnesota).

Indians in state court."[66/] The Court further concluded that, in enacting P.L. 280, Congress had not intended to confer upon the states general, civil, regulatory powers over reservation Indians.[67/]

The Court's interpretation of the reach of P.L. 280 comports with current, congressional policy toward Indian tribes. While some earlier cases dealing with the question of a state's general, regulatory power over reservation Indians had emphasized the assimilationist underpinnings of P.L. 280,[68/] the trend has clearly favored the continuing vitality and strengthening of tribal governments. This policy is evident in the enactment of such legislation as the Indian Reorganization Act,[69/] the ICRA,[70/] the

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66/ Id. at 385.

67/ Id. at 390.

68/ See, e.g., Rincon Band of Mission Indians v. County of San Diego, 324 F.Supp. 372, 374 (S.D. Cal. 1971). The district court's determination that the purpose behind P.L. 280 was to make the Indians full and equal citizens led the court to the conclusion that P.L. 280 authorized the application on Indian reservations of the full "panoply of overlapping and complementary legislation emanating from local and state lawmakers."

69/ 25 U.S.C. § 476 (1970).

70/ 25 U.S.C. §§ 1311, 1321-26 (1970).

Indian Financing Act of 1974,[71] and the Indian Self-Determination and Education Assistance Act of 1975.[72] Thus, under established interpretations of P.L. 280, a state would have no power under authority of that Act, to impose upon the tribes a general, regulatory scheme for the licensing and supervision of on-reservation, Indian nursing homes.

OTHER FEDERAL STATUTES

Other federal statutes must also be considered as potentially affecting on-reservation nursing homes. One such statute, which on its face appears to create a substantial barrier to independent, tribal regulation of nursing homes, provides, in relevant part:

> The Secretary of the Interior, under such rules and regulations as he may prescribe, shall permit the agents and employees of any state to enter upon tribal lands, reservations, or allotments therein...for the purpose of making inspection of health and educational conditions and enforcing sanitation and quarantine regulations....[73]

If this statute were interpreted to be a grant of state jurisdiction over the regulation of health facilities, for establishing and enforcing standards of operation,

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71/ Pub. L. No. 93-262 (1974), 25 U.S.C.A. § 1451 et seq. (Supp. 1978).

72/ 25 U.S.C.A. § 450 et seq.

73/ 25 U.S.C.A. § 231 (1970).

individual tribes would not be free to establish and maintain their own operating procedures and standards for nursing homes.

There is little support, however, for state assertion of any kind of regulatory jurisdiction over health-related matters based on this statute alone. Section 231 has been categorized as a statute which merely authorizes "the administrative application of state law by the Secretary of the Interior directly, or under his aegis."74/ In other words, section 231 is not self-effectuating and, absent affirmative action by the Secretary of the Interior, confers no jurisdiction upon the states.

Action by the Secretary pursuant to §231 is discretionary.75/ He may prescribe whether the state sanitation laws are to apply and, if so, the manner and extent to which they are to be enforced. While the statute states that the Secretary "shall permit" agents of the state to enter the reservation, this has been interpreted under applicable rules of statutory construction by the Department of the Interior to mean the Secretary "may

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74/ Sonosky, State Jurisdiction over Indians in Indian Country, 48 N. Dak. L. Rev. 551, 552 (1972).

75/ Opinion by Acting Solicitor Kirgis, approved by Assistant Secretary Chapman, Department of Interior, Enforcement of Deer Removal and Quarantine Law on Seminole Indian Reservations, 57 I.D. 162, 167 (1940).

permit" the entry of state officers.[76] Section 231 affects no private right and the intent of the statute to give the Secretary discretion is manifested in the provision that action may be taken under "such regulations and conditions as he may prescribe."[77] The statute relates solely to the public duty of the Secretary of the Interior to protect Indians on Indian lands.[78]

At one time, section 231 was implemented by a regulation which set forth a somewhat complicated procedure which had to be followed before state sanitation and quarantine regulations could be enforced on Indian

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76/ Id.; Richbourg Motor Co. v. United States, 281 U.S. 528 (1929); Railroad Co. v. Hecht, 95 U.S. 168 (1877); West Wisconsin Ry. Co. v. Foley, 94 U.S. 100 (1976).

77/ 25 U.S.C. §231.

78/ 57 I.D. at 168.

lands.[79] Thus, even where the Secretary of the Interior has acted upon the authority granted him under Section 231, he has not conferred upon the states general jurisdiction

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79/ 25 C.F.R. §84.78 (1949 ed.) provided:

> State health authorities are authorized to enter upon Indian tribal lands, reservations, or allotments within the respective states for the purpose of making inspection of health conditions looking to the enforcement, except as hereinafter provided, of sanitation and quarantine regulation of the particular state in like manner as such regulations are enforced in the surrounding territory. In connection with and prior to such proposed enforcement, the physician in charge of each reservation shall schedule the state sanitation and quarantine regulation which ought to be enforced upon the reservation together with a statement of any limitations and conditions which should govern the application of such state regulations. Tribal authorities and individual Indians shall be afforded ample opportunity to submit protests or recommendations with respect to specific state regulations thus proposed for extension to the reservation. It shall be the duty of the Superintendent to transmit to the Secretary of the Interior through the Commissioner of Indian Affairs, the schedule of state regulations thus posted, together with any protests or criticisms made by the Indians with respect thereto. Such state regulations as are approved by the Secretary of the Interior shall thereafter be in force upon the reservation subject to such conditions as the Secretary may prescribe. No state law shall be applied within the jurisdiction of any organized tribe which is in conflict with any ordinance or resolution of the tribe.

with respect to health and sanitation matters. On the contrary, the regulation provided that after consideration of such factors as the suitability of the state regulations for the particular reservation, the effect of the enforcement of these state laws upon the Indians and the attitude of the Indians toward such enforcement, only those state regulations as were approved by the Secretary, and subject to such conditions as the Secretary might provide, would be in force on the reservation. More importantly, section 84.78 provided that "no state law shall be applied within the jurisdiction of any organized tribe which is in conflict with any ordinance or resolution of that tribe."80/

Section 84.78 was revoked in 1955 pursuant to the Act of August 5, 1954[81/] which transferred all functions and responsibilities relating to Indian health from the Department of the Interior to HEW. This statute has not been construed to transfer to HEW any jurisdiction over trust lands.[82/] Any power to regulate the use of Indian lands in aid of health and sanitation still rests

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80/ Id.

81/ 68 Stat. 674.

82/ Unpublished Opinion of the Solicitor of the Department of the Interior, M-36768, at 4 (February 7, 1969).

with the Secretary of the Interior.[83] Absent the promulgation of new, implementing regulations, section 231 is not a source of authority for the enforcement of state regulations.[84]

In light of the foregoing, section 231 at present does not appear to present any substantial, jurisdictional barrier to the operation of tribal nursing homes. In fact, it has been suggested that, even in states which have assumed civil and criminal jurisdiction over reservation Indians pursuant to P.L. 280, section 231 might operate to limit the states' jurisdiction.[85] This potential limitation arises out of a part of the "savings clause" of P.L. 280, which states that P.L. 280 shall not operate to authorize regulation of the use of trust

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83/ Id.

84/ Id.; See also Dredge Corp. v. Penny, 362 F.2d 889 (9th Cir. 1966); Superior Sand and Gravel Mining Co. v. Territory of Alaska, 224 F.2d 623 (9th Cir. 1965) (mineral entry statute not effective absent implementing rules and regulations).

There has apparently been little attempt by the states to invoke section 231 as support for an assertion of jurisdiction over reservation Indians. Cf. Snohomish County v. Seattle Disposal Co., 389 U.S. 1016, 1019 (1967) (J.J. Douglas and White dissenting).

85/ Note, The Applicability of the Federal Pollution Acts to Indian Reservations: A Case for Tribal Self-Government, 48 U. Colo. L. Rev. 63, 82 (1963).

property, real or personal, "in a manner inconsistent with any federal treaty, agreement or statute or with any regulation made pursuant thereto."[86] Section 231 might be considered to be a federal law inconsistent with state regulation of health facilities, particularly in view of the fact that the Secretary of the Interior has chosen not to implement the statute.[87]

INDIRECT APPLICATION OF STATE REGULATION

While the basic responsibility for Indian health belongs to the federal government, the federal health care program commonly incorporates some state regulation. As a result, even where an Indian tribe maintained and operated its own nursing home or other health care facility, it could be required to comply with state and, in some cases, local standards imposed upon like non-Indian facilities, although the tribe would not be formally subject to state jurisdiction. Under the present

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86/ 25 U.S.C.A. § 1322(b) (Supp. 1978).

87/ This conclusion would depend to some extent upon whether the particular state health regulations at issue could be considered to regulate the use of trust property. See discussion at p. , supra. The Secretary of the Interior has recognized that § 231 is not sufficiently explicit to authorize him to permit the enforcement of state health regulations on the reservation if enforcement would significantly involve the regulation of Indian lands. Unpub. Op. M-36768, supra note 77.

system, therefore, it appears that as long as a tribe takes maximum advantage of available federal financial support, either through grants or contracts with IHS, the tribe may not be free from state-developed regulations. A discussion of the major sources of funding available for Indian health care facilities illustrates.

As a condition of receipt of a construction grant under the Self-Determination Act to "build, renovate, modernize, or remodel a hospital, clinic, health station or quarters for housing personnel associated with such facilities,"88/ the plans and specifications for the project are required to meet certain minimum standards of construction and equipment.89/ Those standards90/ include a general requirement that the structural design, construction, and fire safety provisions meet the requirements set forth in the National Building Code, 1967, or with all applicable state and local codes and

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88/ 42 C.F.R. §36.110(a) (1976). This language does not explicitly take into account nursing home facilities.

89/ 42 C.F.R. § 36.110(b)(11) (1976); see discussion supra at pp. 9-11.

90/ Established pursuant to section 107 of the Act, 25 U.S.C.A. § 450k.

ordinances, "whichever is more restrictive."[91] HEW's regulations further provide that all facilities must be designed and constructed in accordance with the standards of the Uniform Building Code, 1970, "unless more restrictive state and local codes govern."[92] Furthermore, compliance with applicable state and local zoning codes is required.[93]

The regulations do not explicitly provide for the recission of grants for failure of technical compliance with the applicable standards,[94] but such a construction of the regulations is possible. Therefore, compliance with relevant state standards would appear to be mandatory, at least with respect to construction grants.

There is no direct imposition of state regulations upon tribes or tribal organizations who contract with

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91/ 42 C.F.R. §§ 36.101-36.121, app. A (1976).

92/ Id. at (g).

93/ Id. at (h).

94/ Section 36.115 speaks of possible recission in whole or in part where the performance of a grantee involves "(1) the violation of the rights or endangerment of the health, safety or welfare of any persons, or (2) gross negligence or the mismanagement in the handling or use of funds under the grant." 42 C.F.R. §36.115(a) (1976).

HEW to administer programs currently provided by IHS. The contract proposal need only demonstrate the ability to meet minimum health program and professional standards established by IHS for each of its health service activities. IHS will consider the prevailing standards for the particular IHS activity in the location involved when evaluating a contract proposal.[95/]

MEDICARE AND MEDICAID

The Indian Health Care Improvement Act is of particular import to the issue of possible state regulation of tribal nursing homes. Basically, Title IV of the Act amends the Social Security Act[96/] to make IHS hospitals and skilled nursing facilities eligible for reimbursement under the federal Medicare[97/] and Medicaid[98/] programs. Formerly, IHS facilities were ineligible for Medicare and Medicaid payments under provisions of the Social

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95/ 42 C.F.R. § 36.208(i) (1976).

96/ Major provisions codified at 42 U.S.C. § 1301-82e (1970).

97/ 42 U.S.C.A. §1395qq.

98/ 42 U.S.C.A. §1396j.

Security Act that no payment be made to any federal provider of services.[99] The potential significance of this additional source of funding to Indian health facilities is enormous. It has been estimated that Medicare and Medicaid payments account for over half of the nation's nursing home costs, and the programs are, therefore, critical to the survival of most nursing homes.[100]

The ineligibility of IHS facilities for Medicare and Medicaid participation had severely limited the opportunity for Indians to take advantage of these programs because, other health care facilities often are not accessible to Indians living in remote reservation communities.[101] Under the Health Care Improvement Act, facilities will be eligible whether operated by IHS or by a tribe or tribal organization.

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99/ 42 U.S.C. §§1395f(c), 1395n(d).

100/ Subcomm. on Long Term Care of the Senate Special Comm. on Aging, Nursing Home Care in the United States: Failure in Public Policy, Introductory Report, S. Rep. No. 1420, 93d Cong. 2d Sess. 25 (1974). See also Comments, Regulation of Nursing Homes - Adequate Protection for the Nation's Elderly?, 8 St. Mary's L. J. 309, 311 (1976).

101/ See, e.g., H.R. Rep. No. 1026 (Part I), 94th Cong., 2d Sess. 107 (1976), reprinted in [1976] U.S. Code Cong. & Ad. News 2652, 2745.

In order to utilize these programs, however, participating facilities must meet the same conditions and requirements as other Medicare and Medicaid facilities.[102] In recognition of the fact that many IHS facilities do not presently meet the standards specified for participation in the Medicare and Medicaid programs, Congress provided a one-year grace period for compliance where the facility submits an acceptable plan for achieving compliance.[103] Payments made under the program are to be used by the Secretary to bring IHS facilities into compliance with Medicare and Medicaid standards.[104]

In requiring that IHS facilities ultimately comply with the same conditions and requirements generally applicable to other eligible facilities, the statute does not directly address the question of state or local

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102/ A nursing home which qualifies as a "skilled nursing facility" is eligible under both the Medicare and Medicaid programs. 42 U.S.C. §§ 1395x(j), 1396d(i). Standards of participation appear at 20 C.F.R. §405.1101-405.1101 (1976). A nursing home which qualifies as an "intermediate care facility" is eligible only under Medicaid. 42 U.S.C. §1396d(c). Standards of participation appear at 45 C.F.R. §§249.12, 250.18-250.30.

103/ 42 U.S.C.A. §§1395qq(b), 1396j(b).

104/ 42 U.S.C.A. §§1395qq(c), 1396j.

licensing of such facilities. Indications are that IHS facilities do not have to be licensed by the state, but that the Secretary's certifications of compliance with Medicare standards "are to include assurances that these facilities will meet standards equivalent to licensing requirements."105/

This result is accomplished in part through statutory definitions of those types of facilities eligible for payments. An "intermediate care facility" is an institution which, among other things,

> (1) is licensed under State Law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.
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> The term "intermediate care facility" also includes any institution located in a State on an Indian reservation and is certified by the Secretary... as providing the care and services required under clauses [sic] (1). 106/

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105/ H. Rep. No. 1026 (Part II), 94th Cong. 2d Sess. 3 (1976), reprinted in [1976] U.S. Code Cong. & Ad. News 2652, 2776.

106/ 42 U.S.C. §1396d(c).

This would appear to require that tribal facilities meet all requirements for state licensure as an intermediate care facility, without requiring that they actually be licensed.

A "skilled nursing facility" is defined to include any institution located on an Indian reservation within a state which is certified by the Secretary as a qualified skilled nursing under section 1395x(j) of Title 42.[107] That section requires that where the institution is in a state or locality which provides for the licensing of this type of institution, the institution must either be licensed pursuant to the applicable state or local law, or be approved by the licensing agency as meeting the standards established for licensure.[108] No special provision is made for reservation facilities, so it would appear that tribal skilled nursing homes must comply with state licensure standards. Furthermore,

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107/ 42 U.S.C. §1396d(i).

108/ 42 U.S.C. §1395x(j)(9).

under a literal reading of the statute, the determination that a tribal nursing home meets those standards would have to be made by the state or local agency responsible for licensing institutions of this nature. A more likely interpretation of the statute, however, in light of the legislative history and other pertinent provisions, is that such a determination would be made by the Secretary in the exercise of his responsibility for the certification of these facilities as eligible for payments.

CONCLUSION

The plenary power of the United States over Indian affairs and the well-established national policy of promoting and strengthening Indian tribes as self-governing political entities point to a general exemption of on-reservation Indian nursing homes from state regulation. Public Law 83-280 poses some difficult questions in this regard but, given current judicial interpretations, would seem not to indicate a different result. However, indirect imposition of state standards, through incorporation in federal law, is extensive. The tribes are not completely free to develop their own operational standards, especially where they must rely on federal grants, contracts, or Medicare and Medicaid payments.

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